University of Alberta

Intersectoral Collaboration for Health: The Student Health Initiative

by

Rita Paul-Sen Gupta

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Abstract

Intersectoral collaboration is increasingly being used by different levels of government and funders as a strategy to achieve health goals. The purpose of this investigation was to examine the intersectoral collaboration component of the Student Health Initiative as conceptualized by the originators of the policy and implemented by community planning stakeholders using a case study design. Data was collected through (1) a document review of relevant written materials related to the Student Health Initiative and (2) semi-structured interviews with policy stakeholders who supported the Student Health Initiative at the provincial level and community planning stakeholders who implemented it through the Edmonton Student Health Initiative Partnership. The findings from this study contribute to the development of knowledge in this area and assist policy makers and community planning stakeholders to establish a firm foundation for engaging in intersectoral collaboration.

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CHAPTER 1

Introduction

Intersectoral collaboration is increasingly being promoted by different levels of government and funders as an important strategy to achieve health goals. Over the past several years there have been a number of government-funded initiatives that have mandated intersectoral collaboration at the community level to address a range of issues. Given the increased emphasis and complex nature of this type of approach, it is essential that policy-makers and community planning stakeholders have a good understanding of what is necessary for successful collaboration in both developing and implementing policies that require it.

The Student Health Initiative is an example of a government funded initiative that mandated intersectoral collaboration and was the case selected for closer examination in this study. The Student Health Initiative was announced by the Alberta government in March 1999 as one of the five key priorities under the Alberta Children and Youth Initiative. The goal of the Student Health Initiative is to "improve access to and enhance provision of integrated health and related support services for children with special health needs so that they can participate fully in their education programs to attain their potential and be successful at learning" (Government of Alberta (n.d (a)). The Student Health Initiative was developed through a partnership between Alberta Learning, Health and Wellness, Children's Services, and the Alberta Mental Health Board. At the local level funding for this initiative flowed through a partnership of local school, regional health, child and family service authorities, and regional offices of the Alberta Mental Health

Board. This partnership has the responsibility for collectively establishing priorities, developing joint strategies for service delivery, and sharing accountability for the results (Government of Alberta (n.d. (a)).

Purpose of the Study

The purpose of this study was to examine the intersectoral collaboration component of the Student Health Initiative, as conceptualized by the originators of the policy and implemented by community planning stakeholders within the context of the Edmonton Student Health Initiative Partnership. Data was collected through the completion of a document review and interviews with twelve key stakeholders. The time frame that was examined in this study was primarily from 1999 to 2000. This period was selected as it appeared to be the stage most focussed on developing the collaborative process. The first year (1999/2000) was directed at developing the partnerships, setting priorities, developing strategies, setting up co-ordination mechanisms, hiring staff, and beginning to deliver enhanced/new services. In addition, this timeframe was also the focus of the first evaluation of the Student Health Initiative conducted by Malatest and Associates Ltd. and released in 2001. The second year (2000/2001) was aimed at refining partnership processes, service delivery models, and hiring staff to implement the initiative (Government of Alberta (n.d. (b)).

Research Questions

The specific research questions in this study were as follows:

1. How is intersectoral collaboration conceptualized within the policy?
2. What types of supports were put into place by originators of the policy to promote intersectoral collaboration among community planning stakeholders?
3. How was the intersectoral collaboration component of the policy interpreted and implemented by community planning stakeholders?

CHAPTER 2

Literature Review

Definition

While authors have used a number of different terms to describe collaboration, "intersectoral action for health" appears to be an all-encompassing phrase that can be used to describe a wide range of collaborative relationships that have the goal of improving health. In fact, according to the Canadian Public Health Association (1997), the terms intersectoral action and collaboration have been used interchangeably and are generally thought to include intrasectoral, intersectoral, multisectoral, and multidisciplinary endeavours. Harris, Wise, Hawe, Finlay, & Nutbeam, (1995), based on a review of the literature, as well as extensive consultations with practitioners in the field, proposed the following definition of intersectoral action for health:

> A recognized relationship between part or parts of the health sector with part of parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone (p.24).

The World Health Organization later utilized this definition in 1997 at its international conference on intersectoral action for health to guide delegate discussions (Kriesel & Von Schirnding, 1998) and in a subsequent report on the conference proceedings.

Intersectoral action for health is a complex phenomenon. It involves different types and levels of participants, involves all key stakeholders, takes on various forms, and can be implemented through a range of activities (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1999). Participation in this type of strategy

involves sectors which have been defined as"structures or organizations involved in a common area of activity," (Harris et al., 1995, p.7). These include organizations that focus on specific areas such as education and childcare, large organizational structures such as government bodies, community-based structures and other non-governmental organizations (Harris et al., 1995).

Sectors can also have different levels from which participants can be drawn. These levels can be categorized based on geography (e.g., local/community, provincial, national etc.); placement within the government (e.g., municipal, provincial/territorial, federal); and position within organizations (e.g., senior decision maker, service provider). However, in order to be effective, linkages must occur both within sectors, which is known as vertical collaboration, and between sectors, which is known as horizontal collaboration. It is also essential that all of the key stakeholders be engaged in the process of collaboration (Harris et al., 1995; Federal, Provincial, and Territorial Advisory Committee on Population Health, 1999).

In addition, intersectoral action can take on many "different forms such as cooperative initiatives, alliances, coalitions, and partnerships" (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1999, p.8). It can also be implemented through a wide range of activities such as sharing information, networking, engaging in joint case management, providing sponsorship, co-ordinating services, and developing policies etc. (Harris et al., 1995).

Rationale and Potential Benefits

There are numerous reasons cited in the literature for engaging in collaborative approaches. Some of the documented rationale can also be interpreted as potential benefits of engaging in this type of approach. These include (1) a growing recognition that the ability to address the determinants of health is beyond any one sector (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1999; Harris et al., 1995; Mattessich, Murray-Close, & Monsey, 2001; Nutbeam, 1994) and that this type of approach is necessary to reduce health inequities (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1999; Harris et al., 1995); (2) the need for these types of approaches to address complex health problems (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1999; Harris et al., 1995); (3) the necessity for partnerships to gain entry into certain settings or to access hard to reach populations (Brownson, Dean, Dabney & Brownson, 1998; Levine, Becker, Bone, Stillman, Tuggle, Prentice, Carter & Filippeli, 1992 as cited in Kuhn, Doucet, & Edwards, 1999) and engaging those affected in finding solutions (Harris et al., 1995); (4) preventing duplication (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1999; Harris et al., 1995) and making more effective use of limited resources (Alter & Hage, 1993; Cohen, Baer & Satterwhite, 1998; Federal, Provincial, and Territorial Advisory Committee on Population Health, 1999; Harris et al., 1995); (5) co-ordination of services and programs (Alter & Hage, 1993); (6) increasing the influence of interventions, providing credibility to the issue and process, and making use of the different skills within various sectors (Harris et al., 1995); and (6) mounting knowledge of the factors that contribute to successful intersectoral collaboration and

preliminary evidence of the effectiveness of this type of approach (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1999).

Conditions

Several conditions have been identified as contributing to the success of intersectoral collaboration. Mattessich et al.(2001) through their analysis of 22 studies identified a number of factors which they classified into six broad groupings: environment (history of collaboration, legitimacy of group as a leader, positive political and social atmosphere); membership characteristics (joint respect/trust, representativeness of stakeholders, members see benefit of collaboration, ability to give and take); process and structure (ownership felt for group functioning and outcomes, participation by different levels, flexibility, clear roles and policies, ability to deal with change, acceptable pace of development); communication (open and often, established channels), purpose (clear and reachable goals and objectives, common vision, and distinctive purpose); and resources (adequate staffing, funding, time, and skilled leadership).

However, Mattessich et al., (2001) also note that the relative importance of each of these factors is not known and as such attention should be paid to all of these factors to promote the effectiveness of collaborative initiatives.

Based on a literature review and consultations with key stakeholders in the field, Harris et al., (1995), in a previous work, also identified factors that promote intersectoral action for health. These six factors include: recognizing the need to work together (fulfilling organizational goals and facilitating organizational survival); the existence of

opportunities for organizations in the environment for action (supportive environment and strong motivators for action); the ability to take action (organizational support, resources, and skilled people); the development of a relationship that will facilitate action (clearly outlined, grounded in trust and respect, suitable to the action); planning (consensus on the issues, defined outcomes, and joint ownership), implementing, and evaluating (evaluation is meaningful to each sector and takes into account funding and outcomes) action to the satisfaction of each organization; and attaining sustainable outcomes (monitoring outcomes and provision of support and resources as needed).

Impact

There is some evidence to suggest that intersectoral collaboration can have an impact on process and health outcomes. An international review of published evaluations of alliances/partnerships which focussed on health promotion undertaken by Gillies (as cited in Gillies,1998) found that most of the studies reported individual behaviour change ranging from 3-20% while a number of other studies reported changes in how activities were structured and changes in the broader social and physical environment. As well, a systematic review conducted by Kuhn et. al. (1999) on the effectiveness of coalitions in heart health promotion, tobacco use reduction, and injury prevention found policy changes in one study, statistically significant changes in health status in nine studies, statistically significant changes in health risk behaviours in five studies, and statistically significant changes in knowledge in one study. There was also anecdotal evidence to suggest other benefits such as increased coalition member participation in other community initiatives.

In addition, a case study of a joint initiative between health and social services that was conducted in England found that interagency collaboration resulted in improved communication between professionals, more efficient service delivery, and the development of services (Higgins, Oldman, & Hunter, 1994).

Costs and Barriers

Several costs and barriers of collaborative approaches have been noted in the literature. Johnson, Zorn, Kai Yung Tam, LaMontagne, & Johnson (2003) in their study of stakeholder perspectives on factors that impacted on successful collaboration identified the following key barriers: lack of support/leadership from senior levels within the organization as defined as not getting involved in the planning, having limited knowledge about the initiative, and having other priorities; lack of commitment among partners defined as not meeting one's roles and responsibilities; no shared vision/goals defined as having an agenda and not seeing the entire picture; lack of trust; inadequate funding for collaborative work; and being very territorial.

Other much less frequently mentioned barriers in the study by Johnson et al., (2003) included lack of communication defined as not being given the correct information, using different data systems and languages; not understanding other organization's cultures defined as conceptualizing collaboration differently and having different priorities about what needs to be addressed; lack of negative consequences for non-participation in collaboration; personnel changes; and lack of time defined as being inadequate to meet deadlines and to take part in collaboration. Lack of time was also

found to be a barrier to collaboration by Swan & Morgan (1993) who noted that it was a commonly cited issue.

Additional challenges identified by Higgins, et al., (1994) included differences in professional cultures, training, and education; issues with client confidentiality; and changes in project personnel and within the organization. Other barriers cited by a number of authors included: competition for funding, inadequate training of staff regarding collaboration, limited experience with cooperation and collaboration, turf issues, not having enough staff, organizational competition, agency capacity, and time constraints (Essex, 1999; Flaherty et al., 1998; Swan & Morgan, 1992 as cited in Heffern, McDonald, Wallsten, & Casebeer, 2004)

Gaps in Research

It is clear that intersectoral collaboration is viewed as an important strategy to achieve health goals. The rationale for and potential benefits of participating in this type of approach have been articulated by several authors (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1999; Harris et al., 1995; Mattessich, Murray-Close, & Monsey, 2001; Nutbeam, 1994; Brownson, Dean, Dabney & Brownson, 1998; Levine, Becker, Bone, Stillman, Tuggle, Prentice, Carter & Filippeli, 1992 as cited in Kuhn, Doucet, & Edwards, 1999; Alter & Hage, 1993; Cohen, Baer & Satterwhite, 1998) as have the conditions necessary for its success (Mattessich et al., 2001; Harris et al., 1995). In addition, there is some evidence of the positive impact of intersectoral collaboration (Gillies, 1998; Kuhn, Doucet, & Edwards, 1999; Higgins, Oldman, & Hunter, 1994). However, this approach also has its costs and barriers

(Johnson, Zorn, Kai Yung Tam, LaMontagne, & Johnson, 2003; Swan & Morgan, 1993; Essex, 1999; Flaherty et al., 1998; Higgins, Oldman, & Hunter, 1994; Swan & Morgan, 1992 as cited in Heffern, McDonald, Wallsten, & Casebeer, 2004).

While much is known about intersectoral collaboration, a number of questions still remain that require further research. Key areas that require further exploration include determining the following: the circumstances under which intersectoral collaboration should be implemented; the specific kinds and levels of resources needed to support this type of work; more detail on the benefits, costs, and barriers of this approach; the cost effectiveness of this strategy compared to others to address similar issues; the sustainability of this type of work given the different mandates and funding silos that exist between sectors; the range of outcomes that can be achieved through this approach; and whether evaluation results from these types of initiatives result in policy changes among funders/governmental bodies that mandate intersectoral collaboration.

CHAPTER 3

Research Methods

This study used a case study design to explore the issue of intersectoral collaboration. The specific case examined was the Government of Alberta's Student Health Initiative primarily between 1999- 2000.

Case Study Design

This approach has been defined as "an exploration of a bounded system or a case (or multiple cases) over time through detailed in-depth data collection involving multiple sources of information rich in context" (Creswell, 1998, p. 61). The case under study must be a bounded system. This means that it has certain boundaries (e.g., time and place) and interrelated parts that form a whole (Creswell, 1998). The case itself can take on many forms such as a person, group of people, program, policy etc. (Merriam, 1998).

Another characteristic of case studies is that they are not associated with any one specific data collection method, instead several are used (Merriam, 1998). Examples of sources of evidence used with this methodology include documents, archival records, interviews, direct observations, participant observation, and physical artifacts (Stake, 1995; Yin, 1994 as cited in Tellis, 1997).

Data Collection

Two primary data collection methods were used in this study: (1) a document review and (2) semi-structured interviews.

Document Review

Documents are one source of information that appears to be pertinent to most case studies. Examples of documents include: letters, memos, communiqués, agendas, minutes, written reports, proposals, progress reports, formal site studies/evaluations, newspaper and other articles. Documents play a key role in substantiating and augmenting information obtained from other sources in three ways. They assist in determining the correct spelling and titles/names of organizations identified through interviews; they provide further details to corroborate what has already been collected; and they allow the researcher to draw inferences that can guide other lines of inquiry. The strengths of documents as sources of evidence include the ability to review them a number of times; their inclusion of actual names, references, and event details; and their breadth of coverage. Some of the weaknesses associated with documents are related to their retrievability, possible biased selectivity (e.g., if thorough collection does not happen), reporting bias of the author, and accessibility (Yin, 2003).

For this study, documents were primarily gathered from the Government of Alberta Learning website and staff associated with the Student Health Initiative at both the local and provincial level. As well, during interviews, policy and community planning stakeholders were asked to identify key documents to review.

Interviews

Interviews are seen as a key source of information in case studies (Yin, 2003). Semi-structured interviews are based on the use of an interview guide. This outlines the topic areas and questions to be explored with the participant and represents an important tool in the collection of reliable, comparable qualitative data. However, even though a

written guide is used, the interviewer retains the ability to determine which leads to follow. This type of interview works well when the researcher is working with people who are used to efficient management of their time such as managers, bureaucrats, and elite members of the community (Bernard, 2000).

In developing the interview guide, the researcher needs to consider the thematic and dynamic aspects of questions; the type, wording, and order of questions; and the appropriate use of probes. The thematic dimension refers to how the question relates to the research topic while the dynamic dimension refers to whether the question promotes a positive interaction (Kvale, 1996). The questions used in the key informant interviews were developed based on key concepts that were identified in the literature review.

For this study, semi-structured interviews were conducted with twelve subjects drawn from two groups in April 2004. At the policy level, five interviews were conducted with individuals involved in the Student Health Initiative at the provincial level using a semi-structured interview guide (see Appendix A). Involvement in the initiative ranged from participation in the development of the policy to overseeing and supporting its implementation across the province. Key factors taken into consideration in selecting participants for interviews was the extent of their role in both shaping and overseeing the implementation of the Student Health Initiative within the timeframe under study. At the community planning stakeholder level, seven interviews were conducted with individuals involved with the implementation of the Edmonton Student Health Initiative using a semi-structured interview guide (see Appendix B). Important factors taken into consideration in selecting participants for interviews were the length and extent of their involvement in implementing this initiative from its outset. The interviews were

approximately one hour in length and were tape recorded and later transcribed. In addition, the researcher took notes during the interview.

To identify participants for interviews, a preliminary list was first developed based on an exploration of the feasibility of conducting this study. Once this list was generated, snowball sampling was used to identify additional key informants at both the policy and community planning levels. Each of these potential participants received a phone call from the research assistant asking them whether an information letter (Appendix C) could be e-mailed to them and requesting that they e-mail the research assistant back if there were interested in participating in the study.

Data Analysis

The research questions, which examine different aspects of intersectoral collaboration at both the policy and community planning stakeholder level, formed the general framework for the data analysis. Data collected through the document review and from interview transcripts and notes were compiled and organized, generated into categories and hand coded by the researcher. Participants were contacted to verify the accuracy of the researcher's interpretation. The following table outlines the approach to the data analysis.

Table 1:

Approach to Data Analysis

RESEARCH QUESTION	DATA TYPE	CATEGORIES EXAMINED
How is intersectoral collaboration conceptualized within the policy?	Document and Interview Text	Levels (e.g., geography, placement within the government, and position within organizations). Forms (e.g., as cooperative initiatives, alliances, coalitions, and partnerships) Activities (e.g., sharing information, networking, engaging in joint case management, providing sponsorship, co-ordinating services, and developing policies etc.). New emergent themes.
What types of supports were put in place by originators of the policy to promote intersectoral collaboration among community planning stakeholders?	Document and Interview Text	Conditions (environment; membership characteristics; process and structure; communication; purpose; and resources). Other factors (e.g core skills and knowledge among members; provision of supports (e.g., technical assistance, training, and orientation); shared power; commitment to involving community members in agenda setting, policy development, and implementation and utilizing structures that maximize community involvement; and achieving sustainable outcomes. Strategies to reduce costs and individual and structural barriers. New emergent themes.
How was the intersectoral collaboration component of the policy interpreted	Document and Interview Text	Levels (e.g., geography, placement within the government, and position within organizations). Forms (e.g., as cooperative initiatives,

RESEARCH QUESTION	DATA TYPE	CATEGORIES EXAMINED
and implemented by community planning stakeholders?		alliances, coalitions, and partnerships). Activities (e.g., sharing information, networking, engaging in joint case management, providing sponsorship, co-ordinating services, and developing policies etc.). New emergent themes. Conditions environment; membership characteristics; process and structure; communication; purpose; and resources. Other factors (e.g core skills and knowledge among members; provision of supports (e.g., technical assistance, training, and orientation); shared power; commitment to involving community members in agenda setting, policy development, and implementation and utilizing structures that maximize community involvement; and achieving sustainable outcomes. Strategies to reduce costs and individual and structural barriers. New emergent themes.

Validity and Dependability

The trustworthiness of research results is based on the consideration given to the issues of validity and reliability (Merriam, 1998). Given that the term reliability in its traditional usage does not appear to fit with qualitative research, it has been suggested that the term dependability be used instead (Guba & Lincoln, 1985 as cited in Merriam, 1998). Internal validity refers to how closely the research findings match reality. There

are a number of strategies that can be utilized to increase the internal validity of a study. These include triangulation, member checks, long-term observation, peer examination, participatory research, and articulation of researcher biases (Merriam, 1998). Internal validity in this case study was increased by using triangulation and member checks.

Triangulation refers to the use of a number of data sources or methods to substantiate emerging findings (Merriam, 1998). In this study, data was obtained by reviewing a wide range of documents and through interviewing key stakeholders at both policy and community planning levels. Member checks refer to sharing the data and preliminary interpretations with those individuals from whom they were derived (Merriam, 1998). All twelve subjects were contacted by phone or e-mail and requested to verify the accuracy of the researcher's interpretation of the data. Of those contacted, one indicated that due to time constraints a review would not be possible. Seven others indicated a willingness to conduct a review and provided written feedback on the findings. They were asked to comment on the clarity and accuracy of the findings and the protection of their identity. Their feedback has been incorporated into the findings section.

Dependability refers to whether the results make sense given the data that was collected. There are a number of strategies that can be used to increase the dependability of results. These include stating the investigator's position on various aspects of the study, triangulation (previously described) and an audit trail which involves detailing how data was collected, categories were derived, and how decisions were made throughout the study (Merriam, 1998). The dependability of the case study results were

increased by using triangulation and describing in detail the study methods and procedures and how the findings were generated from the data.

Ethical Considerations

Informed consent and anonymity/confidentiality were the two main ethical issues related to this study. All prospective participants were e-mailed a letter describing the research study and inviting them to participate in the project by contacting the researcher's assistant. Prior to conducting the interview, the researcher reviewed the purpose of the study with the participants and informed them that their participation was voluntary, that they were free to decline answering any questions, that they could withdraw from the interview at any time and that any information given would be kept confidential. Once this was explained, the researcher obtained a signed consent form from each of the participants (Appendix D).

To protect the anonymity and confidentiality of participants, code numbers replaced names and other identifying material on the transcripts, notes and document review. As well, all interview records were stored in a locked cabinet and consent forms and code lists were stored in another locked cabinet to which only the researcher had access. In addition, no identifying information will be provided when reporting data or disseminating findings. The original research data will be retained for five years following the completion of the research.

CHAPTER 4

Findings

The study findings are presented under each of the research questions. First, the conceptualization of intersectoral collaboration within the Student Health initiative is described. This description is followed by the identification of supports put into place to promote intersectoral collaboration at the community level. Then, the interpretation and implementation by community planning stakeholders of the intersectoral component of the Student Health Initiative is presented. The findings from both interviews with policy and community planning stakeholders and from a document review of pertinent written materials identified through key stakeholder interviews and/or the researcher's own efforts are reported.

A number of documents have been produced on the Student Health Initiative; however, very little detailed information was found on intersectoral collaboration within the documents found within the public realm. The participants interviewed as part of this study identified a range of key documents to review; however, it was noted by one respondent at the provincial level and one respondent at the community level that very little documentation actually existed on the collaboration aspect of this initiative. This was confirmed by a key contact identified by several participants as being extremely knowledgeable about the documents related to the Student Health Initiative.

How is Intersectoral Collaboration Conceptualized within the Policy?

To answer this question, policy stakeholders were asked about the rationale for mandating intersectoral collaboration and its meaning within the Student Health

Initiative. As well, a number of key documents were reviewed. These included the Alberta Children's Initiative: An Agenda for Joint Action, the Student Health Initiative Partnership Planning Guides for 1999-2000 (1999)and Alberta Children's Initiative: An Agenda for Joint Action, the Student Health Initiative Partnership Planning Guides 2000-2001 (2000), and a Developmental Decision-Making Matrix (Lynch, 2000).

Mandating Intersectoral Collaboration

A number of reasons were provided by policy stakeholders for why the government chose to mandate intersectoral collaboration within the Student Health Initiative. One reason was that it was viewed as a way of promoting collective responsibility for addressing the needs of children among different sectors.

> …needing to create partnerships because we've got a collective responsibility. We can't say, "Oh, it's your job, and you're not doing your job." We need to figure out how we need to work together on this. We need to collectively make decisions about who are the priority kids for getting the services.

As well, mandating collaboration was deemed as necessary by two respondents in order for collaboration to actually occur. One respondent indicated that if the initiative was not cross sectoral than a dominant group could go off and address the issues of importance from their sector's perspective but not necessarily meet the "collective needs of the child". The other respondent noted that "a collaborative structure" for this initiative was required because there had been instances in the past when collaboration had not occurred when funds were provided to one particular group.

> I think the reason why it wasn't just turned over to the local level without any requirements around collaboration was probably because of our experiences at the provincial level and watching what happens to money. As you allocate money out, the person who owns the money usually calls the shots…We had too much experience with people not collaborating when there is an owner of the funds.

Other reasons noted for mandating intersectoral collaboration by one key informant was that it was necessary to facilitate the coordination of services and to prevent working in silos and duplicating services. "…partners had struggled with providing services in silos..." The latter two issues were also mentioned by another respondent as concerns shared at senior levels within government. No specific reference was made within the documents reviewed about the rationale for mandating intersectoral collaboration.

Defining Intersectoral Collaboration

From the interviews conducted with policy stakeholders it did not appear as thought an explicit definition of intersectoral collaboration was provided within the Student Health Initiative. It was noted that a planning guide developed for this initiative did outline governmental expectations regarding intersectoral collaboration within the community. "… This is the money, here is the guide, this is what you have to do, and you must submit a plan…"

The guide was the Student Health Initiative Partnership Planning Guide (1999; 2000) developed by the Government of Alberta. It summarized funding information and outlined principles and joint service planning and yearly reporting requirements for the Student Health Initiative. A review of the 1999-2000 and 2000-2001 guides revealed that the government had identified the level and types of sectors to be involved, the form of the collaboration, and the range of activities to be undertaken within the initiative. At the community level, it was noted that for each Student Health Partnership the following sectors needed to be involved: public school jurisdictions, regional health authorities, regional offices of the Alberta Mental Health Board, child and family services authorities, and other school authorities. It was also clear that there was to be consumer involvement

in the planning of this initiative. The form of the collaboration chosen by the government was partnerships and the activities of the collaborative were to be centered on the provision of integrated and accessible health and related services and supports for children identified with special needs (Student Health Partnership Planning Guide, 1999).

Other expectations outlined in the planning guides related to collaboration included requiring that the partnerships develop a shared vision; establish open and clear communication; and utilize shared responsibility for decision-making and action. As well, it was stipulated that even though partners may be representing different numbers of children that there would be equity in decision-making among partners in priority setting, development of strategies, and funding decisions. In addition, the importance of continuing to develop partnerships and in particular decision-making and accountability processes was noted (Student Health Partnership Planning Guide, 2000).

In addition to the planning guide, two respondents also mentioned the development of tools at the provincial level to explain collaboration. One respondent made reference to a power point presentation that was developed for a conference, that outlined some guidelines related to collaboration. These guidelines were derived from discussions with individuals in the community about the Student Health Initiative. Examples of the guidelines included building trust, having adequate representation at the table, involving consumers, articulating goals and outcomes, supporting the change process but building in flexibility, having responsive leadership, balancing top down and bottom up approaches etc.

As well, both key informants made reference to a chart, the Developmental Decision-Making Matrix (Lynch, 2000) that they used with their counterparts that

outlined the meaning of cooperation, coordination, collaboration, and integration. It was noted by one of the key stakeholders that this content was incorporated into speaking notes to community planning stakeholders and into presentations at the ministerial level on lessons learned about collaboration.

The Developmental Decision-Making Matrix described the four concepts noted above according to the domains of decision-making, resources, goals, and operations. The characteristics of collaboration and integration are noted below as both of these concepts appeared in the Student Health Initiative Partnership Planning Guides (1999; 2000).

Collaboration.

a) Decision-making-Decisions are still unilateral but extensive input is from other systems and others affected are geared to achieve shared outcomes.
b) Resources- Individual system remains accountable for the use of resources, certain amount of pooling/joint use of resources to achieve mutual goals; equality of contribution among partners.
c) Goal Setting- Goals still set by each partner to meet shared outcomes. Shared outcomes identified through consensus process involving all appropriate/affected stakeholders.
d) Operations- Protocols and memoranda of understanding are used to define joint work. Joint action on specific projects, multi-disciplinary case conferencing occurs on "as- needs" basis. Some blurring and ambiguity evident in the field among workers from various disciplines; some loaning or secondments between services providers.

Integration.

a) Decision Making-Decision making is shared and achieved through consensus process to achieve shared outcomes. Responsibility and accountability for decisions are shared among the participating partners.

b) Resources-Resources are all pooled and decisions on their use mutual among partners to achieve shared outcomes; each partner still shared equally in the decision making process and accountability.

c) Goal Setting- Mutual goals developed jointly with all stakeholders to achieve shared outcomes. All partners held accountable for achievement of goals.

d) Operations- Mergers and consolidations common. Multi-disciplinary, case conferencing the norm. Significant stakeholders involved in joint action, shared responsibility and multi-disciplinary crossovers common.

As well, it was noted by one respondent that there was an effort by the government to more clearly articulate what it meant by collaborative models over time with the implementation of the Alberta Children's Initiative (now known as the Alberta Children and Youth Initiative). In 1998, the Government of Alberta published "The Alberta Children's Initiative: An Agenda for Joint Action". This document outlined a business plan to guide various ministries within government in collaborative planning for children and families and included a vision, goals, expected outcomes, strategies, and a work plan. Partnering across, between, and with various sectors was noted as being important to the achievement of results. A number of different priority areas were

identified for implementation including "an initiative to provide integrated service delivery for children with special health needs in the school setting" (p.11)

What Types of Supports Were put into Place by Originators of the Policy to Promote Intersectoral Collaboration Among Community Planning Stakeholders?

To answer this question, both policy and community planning stakeholders were asked about the supports that were put into place to facilitate collaboration at the community level and the barriers that existed. As well, the Student Health Initiative Partnership Planning Guides for 1999-2000 and 2000-2001 and the Summary Report of the Student Health Initiative Evaluation Project (2001) were reviewed to identify supports. The latter document was also reviewed to identify barriers as was a study of six Student Health Initiative partnerships across Alberta (2004).

Supports to Intersectoral Collaboration

While sometimes highlighting different aspects, both types of stakeholders identified very similar supports that were put into place to facilitate intersectoral collaboration at the community level. Those cited by most policy stakeholders and by two or three community planning stakeholders included funding, written materials, co-ordinators, the Provincial Working Group, facilitation support, and forums.

Funding Administrative funds were a support named by policy stakeholders. It was noted that this enabled many partnerships to hire a local coordinator/consultant or in some cases to increase the support already being provided by one of the partnering organizations. These positions were viewed as helpful in assisting partnerships to

collaborate. The ability to hire independent consultants with the funds provided was also identified by a community planning stakeholder.

Other supports named by those at the community level included the overall funding for the initiative and the funds provided for infrastructure such as facilities. The Student Health Initiative Partnership Planning Guides indicated that 25.6 million dollars annually had been allocated for this initiative and that 4.5% of the funding provided to each partnership could be used for administrative costs (Government of Alberta, 1999). However, the adequacy of this amount along with other funding related concerns were raised by some of the key stakeholders interviewed and in some of the documents reviewed. These are discussed further under barriers to intersectoral collaboration.

Written materials. Most policy stakeholders and one community planning stakeholder identified the Student Health Initiative Partnership Planning Guide as a support noting that while it outlined expectations regarding the initiative, it did not address the process or the how to aspects of collaboration per se. "…there were planning guides in terms of goals, objectives and helping to define what you had to do to get dollars. They weren't planning guides in terms of the process you need to get there." It was noted by one policy respondent that the planning guides were not intended to prescribe the process of collaboration and that partners were expected to explore ways to work together within the broad parameters of the Student Health Initiative.

Other written materials named at the community level included publications on collaboration developed by the government but that were not provided as part of the Student Health Initiative and letters to key stakeholders about the initiative.

The evaluation report of the Student Health Initiative by Malatest & Associates Ltd. (2001) identified a range of resources provided by the Provincial Working Group and cited the percent of partnerships across the province that found them to be helpful or very helpful. These have been noted in brackets beside the names of the resources. The written materials included a list of charter schools, private schools and private ECS operators (87.5%), the Student Health Initiative Partnership Planning Guide (87.5%), the Student Health Initiative Matrix of Authority Boundaries (79.2%), the FOIP Bulletin (75%), and access to the Student Health Initiative Website-Questions and Answers (50%). The latter resource was also named by one policy stakeholder.

Co-ordinators. Co-ordinators were identified as a support to the initiative. At the policy level, the provincial coordinator was seen as the key interface between the partnerships and the government and viewed as a resource person and a mediator when conflicts arose within the partnerships. "…the coordinator especially spent a huge amount of time working with different groups". As noted earlier, the ability of partnerships to hire co-ordinators at the local level was seen as assisting with collaboration. At the community level, reference was primarily made to the ESHIP coordinator.

> The coordinator I think has done a tremendous amount of work. In terms of working and pulling this stuff together and working with the Steering Committee. So I think to my way of thinking, that's probably been the largest piece that they did-that's to actually hire an FTE to help, to put the responsibility to coordinate the leadership on-site…

Provincial Working Group. The provincial working group was another support that was named. At the policy level it was noted that when resolution could not be reached within local partnerships, members of the provincial working group were often engaged and team visits were conducted with groups. As well, one key informant noted

that ministry support was available to partnerships to assist them in developing their joint service plans. Interestingly, one respondent noted that the government had assumed that the provincial working group would only be required for the short term; however, it still exists today. While also named as a support at the local level, one respondent indicated that this group was viewed primarily as a resource for questions about the initiative but not as a support for issues that arose from the collaborative process. For this function it was noted that a party independent of the province might have been better utilized. One policy respondent disagreed with this view of the provincial working group and indicated that it was intended to address questions, issues, and concerns about the Student Health Initiative and steps taken locally by partners.

The Provincial Working Group consists of representatives from Alberta Learning, Health and Wellness, Children's Services, and the Alberta Mental Health Board as well as the provincial co-ordinator and this is one of the inter-ministerial groups at the provincial level that guides and resolves issues in relation to the Student Health Initiative. The evaluation report of the Student Health Initiative found that 45.9% of the partnerships across the province found access to the Provincial Working Group helpful or very helpful and that 56% found the overall support provided by this group to the development of the partnership to be helpful or very helpful. However, it was felt the launch and implementation of the Student Health Initiative could have been better supported by providing more provincial support to the establishment of partnerships and the formation of the service plans (Malatest & Associates Ltd., 2001).

Facilitation Support. The availability of facilitation services through Alberta Community Development for any partnership that requested it was another support that

was named by both types of stakeholders. However, only one of the two community planning stakeholders actually named this organization. It was noted by one respondent that while this resource was available it was not utilized by the Edmonton Student Health Initiative Partnership. Similarly, at the policy level, it was noted that few partnerships accessed this assistance for a number of reasons.

Firstly, there was a perception that asking for help would suggest a problem. As well, at the beginning of the initiative many partnerships were very task oriented and focussed solely on understanding the requirements outlined in the planning guide and completing their service plans. A couple of other policy respondents also noted that feelings varied about accepting government assistance with the initiative across different communities-some welcomed the additional help while others did not want it. "Now some didn't want the help, you know they didn't want government involved…So some communities like that hands-off approach, others were happy to take whatever you would offer them".

Facilitation support from Alberta Community Development was a support that was named in the first Student Health Initiative Partnership Planning Guide (1999). However, the evaluation of the Student Health Initiative by Malatest & Associates Ltd. (2001) found that only 29.2% of partnerships across the province found the services provided by Alberta Community Development to be helpful or very helpful. A footnote in the evaluation report provides some possible reasons for this finding. Several people noted that due to the lack of staff familiarity with health or education programs/policies, they were of limited assistance in the preliminary consultations and meetings of partnerships.

Forums. Forums to promote sharing among the various partnerships across the province were named by policy stakeholders as another support that was put into place and emphasized as being very important by one respondent. However, it was noted by one respondent that this was not part of the original thinking but in fact came much later and that obtaining governmental support to actually conduct the forums was challenging. A couple of community planning stakeholders also made reference to workshops that were implemented by the province. The evaluation of the Student Health Initiative by Malatest & Associates Ltd. (2001) revealed that the launch and implementation of this initiative could have been better supported by providing opportunities for information sharing among partnerships in the early design and implementation phase of the project.

Others. Other supports mentioned by policy stakeholders included creating a website, developing a newsletter, providing funds for one time purchases, and forming various task groups within the government to support different aspects of the Student Health Initiative. Interestingly, one respondent noted that in the early thinking about this initiative it had not occurred to anyone that collaboration in and of itself would require support. "I think quite frankly it hadn't occurred to anybody that collaboration would be in of itself something that needed support…it didn't occur to us". Another policy respondent disagreed with this statement and indicated that there was a recognition that supports would be needed for those not accustomed to partnering with each other.

Community planning stakeholders also indicated that the identification of partners that had to be involved in the initiative was helpful. Both types of stakeholders also named the information sessions that were provided on this initiative as a support. Provision of six information sessions around the province about the Student Health

Initiative were a support listed in the first planning guide (1999). It was noted that subsequent information sessions were conducted when changes were made to the planning guide that was issued yearly.

Barriers to Intersectoral Collaboration

In addition to supports, both types of stakeholders identified several barriers to intersectoral collaboration. Many of these were similar. Those cited by least two policy stakeholders and by a number of community planning stakeholders included funding, miscommunication, time, and professional requirements as barriers to intersectoral collaboration. Another key barrier identified by policy stakeholders were differences that existed across the province while community planning stakeholders identified organizational differences as a challenge.

Funding. Funding was noted as a significant challenge by policy stakeholders; however, different aspects were highlighted as being problematic. Inadequate administrative funds for all of the partnerships to hire a coordinator and a funding formula that did not enable partnerships to predict the amount of funding they would receive in the upcoming year were cited as barriers by one respondent.

> I think that the whole funding methodology became a barrier, a huge barrier…There was no predictability…if you didn't have a change in enrollment you assumed that you would get the same amount of money the following year, but you didn't. So there was huge growth somewhere-it would pull dollars because it was a fixed pot of money.

Another indicated that the funding received for the Student Health Initiative was much less than what was originally requested which necessitated a rethinking of what could be accomplished. As well, it was noted that the funding structure needed to support collaboration across ministries did not exist at the local level. However, this problem had

been anticipated and was resolved through the development of a banker's strategy whereby one partner could hold the funds on behalf of the collaborative.

Interestingly, another respondent noted that the current model upon which the Government of Alberta is based does not recognize shared funding between ministries and that this is a challenge that still remains. In addition, at the end of the first three years of funding, one of the greatest challenges noted by one respondent involved determining who would go forward to request funds for the next three years. Instead of a joint submission, it appears as though the Minister of Learning took the lead for acquiring funding for upcoming years.

One community planning stakeholder also indicated that the monies provided for administration were low. Other issues that were raised included feeling that the funding that was originally provided for the initiative was inadequate to meet the needs that existed within the community. This was evidenced by that fact that waiting lists existed for children to receive services. As well, one respondent noted that the funding did not take into account increases in the cost of living. Concerns were also raised by two respondents about the sustainability of the initiative given its funding.

The evaluation report by Malatest & Associates Ltd. (2001) also identified funding issues. It was noted that initially the larger partners experienced some difficulty in adjusting to the new model in which pooled funding was used to provide services identified by a range of partners including smaller organizations. There were concerns regarding how funding allocations were determined; some confusion about how the funds could be allocated, that is were they to be pooled or were the monies to be divided among the partners; concerns about the inadequacy of funding for administrative costs,

especially during the initial start-up and implementation; and the inability of smaller partnerships to hire coordinators due to lack of funding. Heffern et al., (2004) in their study of six Student Health Initiative Partnerships across Alberta also identified inadequate resources for hiring staff to fulfill these types of functions as a barrier.

Additional concerns were highlighted in relation to items that were not funded but where costs were incurred by the partners, namely for space for new staff, improving facilities, secretarial and accounting services, as well as for computers, telephones, and communications. While some partnerships indicated receiving support from Alberta Infrastructure, many indicated that their organizations incurred the expense. The sustainability of the initiative was another issue of concern as cost of living increases and wage settlements were not considered in the funding. As well, the lack of long term commitment (beyond three years) to the initiative was problematic (Malatest & Associates Ltd., 2001).

Communication issues. Lack of clarity regarding various aspects of the Student Health Initiative was another challenge. Policy stakeholders indicated that it appeared unclear among the partnerships that the collaborative held the authority, not any individual partner. For instance, the role of the banker was not well understood among the various partnerships.

As well, one respondent noted that there was a lack of clarity regarding the purpose of the initiative that resulted in some partnerships not understanding the parameters of the project and proposing initiatives outside of its scope. "We didn't anticipate for example how difficult it was going to be for people in the partnership to understand the essential purposes of the Student Health Initiative". Community planning

stakeholders indicated that the target population for this initiative was not made clear in the initial communication (e.g., children with mild-moderate or severe disabilities).

The evaluation report by Malatest & Associates Ltd. (2001) also identified some issues with communication. Interestingly, findings from the provincial level indicated that there was a lack of clarity regarding program ownership within the Provincial Working Group. This was related to the perception that this was an Alberta Learning initiative rather than a joint effort given that the funding was channeled through that particular ministry. As well, the roles and responsibilities of members of the Provincial Working Group were also cited as being unclear. At the community level, a the lack of clarity regarding partnership boundaries was noted which made it challenging to identify who to partner with and created staffing issues as some organizations had to participate in more than one partnership.

Time. Time was also cited as a barrier; however, different aspects were highlighted as problematic by the two policy respondents. One stakeholder noted that the time frames for partnerships to come together to develop a plan were too short and that this was known within government but that they were limited by the funding cycle. Another noted that building partnerships was very time consuming and that the resources provided did not account for this. At the community level, the huge time commitment required by the various partnering organizations to implement this initiative was consistently cited as an issue.

The evaluation report by Malatest & Associates Ltd. (2001) also identified issues related to time. At the Provincial Working Group level, it was noted that this initiative required a significant amount of time. As well, the limited time available (three months)

between announcing the initiative and expecting partnerships to develop, complete a needs assessment, and submit a joint service plan was a consistent issue that was raised. In addition, meeting the government's reporting requirement for this initiative in the form of the joint service plan and annual reports were also challenging as they required a great deal of time and resources from organizations and because it was extremely difficult to determine current expenditures regarding student health services (Malatest & Associates Ltd., 2001).

Professional requirements. One barrier that was strongly emphasized by one policy stakeholder as being a very large problem was information sharing among partners due to different legislation governing practice. This issue was also raised by two community planning stakeholders. To address this issue, the government developed a cross ministry committee to examine information sharing.

> ...People had different legislation that they have to follow. There's many different ...pieces of legislation for different bodies. Mental Health has more stringent ones, having to follow the Mental Health Act which supercedes any of the other things...figured out how to get around things under our Freedom of Information and Privacy Act but then we passed a new legislation, the Health Information Act, which excluded anyone outside of the health arena such as education, and it didn't have any amendments that lent itself to collaboration. So that was a huge barrier and I'm not sure that has been resolved yet.

One respondent highlighted limitations related to who could be hired through this initiative (e.g., professionals and not paraprofessionals) while another raised the issue of differences in the meaning of the same words between professions.

Differences across the province. Differences between various areas within the province were another barrier noted by policy stakeholders. The capacity to do this work was not the same across the province and this did not appear to have been taken into consideration. One policy respondent disagreed with this statement indicating that

supports available to community took this into account. One community planning stakeholder also noted that the differing needs of various regions throughout the province were not reflected upon.

Organizational differences. A number of organizational differences were also cited as barriers to intersectoral collaboration. These included differing organizational structures/styles which impacted on how issues were addressed, varying organizational responsibilities, and the reporting relationship between organizations and their respective ministries. "… one of the things that was very intricate and again it took us a long time to figure it out is that different groups have different relationships with their ministries".

Other. Other barriers identified by single policy respondents were issues related to hiring authority, trust at different levels within the initiative, organizational culture, changes in geographic boundaries as part of regionalization, overrepresentation at the table from some sectors, limited resources of small agencies to participate in planning and high turnover within partnerships. Changing membership was also noted as a barrier by two community planning stakeholders. Barriers at the local level were addressed as they arose according to two policy stakeholders while another indicated that some of the supports put into place such as the provincial coordinator, website with FAQs, the newsletter, forums, and team visits were to deal with barriers. Challenges emphasized by one or two community planning stakeholders included power issues, lack of group process tools/resources, and the collaborative not being a legal entity.

In the evaluation report of the Student Health Initiative conducted by Malatest & Associates Ltd. (2001), changeover in membership was identified as a problem within the Provincial Working Group and it was suggested that seconding a core group to support

this initiative at the provincial level would have been useful (Malatest & Associates Ltd., 2001). Other barriers noted by Heffern et al. (2004) included not having the right people at the table, not providing separate venues for policy decision-making and operational planning, and not having a history of collaboration and consistent membership

How was the Intersectoral Collaboration Component of the Policy Interpreted and Implemented by Community Planning Stakeholders?

To answer this question, community planning stakeholders were asked about what intersectoral collaboration meant to them and how this compared to its conceptualization within the Student Health Initiative. In addition, they were asked to discuss various aspects of the collaborative process including facilitating factors, benefits, and costs. As well, they were asked to share what they had learned about intersectoral collaboration from this experience.

Defining Intersectoral Collaboration

While using slightly different terminology, most of the respondents viewed intersectoral collaboration as a number of sectors/partners or services working together toward a common goal or for a common client. Responses to the questions about the similarity or difference between key stakeholder definitions of intersectoral collaboration and that provided through the Student Health Initiative varied.

A couple of respondents felt that their definitions were similar to how collaboration was conceptualized within the initiative. Four other stakeholders noted that while guidelines or expectations regarding collaboration had been developed by the government, the concept was actually operationalized by the community. "I think the

guidelines and the initial materials provided a basic…but then it's interpreted and it's put into action". One respondent indicated that there was a lack of clarity regarding how intersectoral collaboration was conceptualized within the Student Health Initiative citing for instance the differences in people's understanding of the types of needs that the initiative would address e.g., students with mild-moderate or severe disabilities.

Factors that Promoted Intersectoral Collaboration

The factors most often noted as promoting intersectoral collaboration by community planning stakeholders were having a history of collaboration, commitment to addressing the issue, and having the parameters of the initiative outlined and funded. "Well, certainly that there was money, and the only way to access the money was to develop a plan collaboratively. So that was definitely another incentive." A number of respondents indicated that some of the major stakeholders in the community were already working together on different issues prior to the inception of the Student Health Initiative. However, one respondent noted that while these particular partners had a great deal of opportunity to collaborate, smaller groups had not necessarily been part of those processes. Another noted that the presence of a pre-formed group in the community that was already working to address children's issues was a significant help, particularly in pulling together the initial plan for the implementation of the initiative. "…we pulled a plan together very quickly…I think that was possible because the core group had been together over time already and had established a fair bit of trust".

The commitment to address the issue whether it was the need for services or how services would be provided was another factor. As well, requiring collaboration as a part of this initiative/condition of funding was a further incentive cited for working together

within the community. "…so, I think we all knew that there was tremendous need and that we should do our best to access those services to better meet the needs of our ____." Other factors noted by one or two respondents included leadership, trust between members, appropriate and consistent membership, high level support for the initiative from partnering organizations, and the opportunity to interact with other Student Health Initiative partnerships through provincial meetings.

A study of six Student Health Initiative Partnerships across Alberta involving interviews with key stakeholders identified four factors that facilitated collaborative activity. These included having the right people at the table, providing separate venues for policy decision-making and operational planning, having a history of collaboration and consistent membership, and adequate support. Some of the aspects related to having the right people at the table included having a strong chairperson who possessed particular characteristics; equal representation from the various sectors; and participation of decision-makers at the table. Having different committees to deal with policy decisions related to the development of the service plan and operational planning was also deemed to be important (Heffern et al., 2004).

Partnerships that had been operating prior to this initiative had cultivated a "culture of reciprocity and collaboration" (Heffern et al., 2004, p.28) that was helpful to the planning process. As well, those with stable memberships appeared to do better than so where the membership changed often. Another factor that was named was the availability of adequate resources to meet the requirements of the initiative. For instance, those partnerships that had enough funding to create a particular position or to hire

consultants to assist with the work indicated that they were less frustrated and more successful in collaboration (Heffern et al., 2004).

Benefits of Intersectoral Collaboration

A range of benefits of intersectoral collaboration were noted by community planning stakeholders. The benefits identified by the most respondents included understanding one another's organizations, developing key contacts to address other issues and/or partner on other initiatives, and improving services for children. The types of improvements in services noted by the key stakeholders included increased numbers of children served and the development of new services. "…more kids got service. That was really the overriding primary benefit"

Most of the benefits identified were wide-ranging and only named by single respondents. These included integration of services, linkages among initiatives, profiling one's organization, improved front line collaboration in some areas, developing common philosophies regarding children, broad engagement within the schools from the top right down to the parents, sharing of learning and program statistics, working on best practices, implementing different service delivery models, and developing a team. It was interesting to note that one respondent indicated a lack of organizational benefits of the initiative highlighting some of the challenges it posed in terms of the systems that needed to be put in place to implement the project and the lack of resources provided to do so.

Several benefits of collaboration were also described in the evaluation report on the Student Health Initiative. It was noted that this project served to improve collaboration between organizations providing student health services. As well, over 75% of the partnerships felt that the Student Health Initiative improved information sharing

among partners, 88% reported improvements in planning and decision-making and 68% indicated improvements in collaboration regarding pooled funding (Malatest & Associates Ltd., 2001). Improved communication and collaboration were also noted as successes of the Student Health Initiative (Government of Alberta, 2001).

In addition, Malatest & Associates Ltd. (2001) found that most the partnerships agreed or strongly agreed that the Student Health Initiative enhanced their knowledge of partnering organizations' programs and services and that it improved coordination of services. Some other unexpected positive outcomes included being used as a model for other joint initiatives, increased knowledge of partner services resulting in improvements in referrals, and creation of a receptive climate for cross-department projects.

Costs of Intersectoral Collaboration

In addition to the benefits, there were costs associated with intersectoral collaboration. The key cost identified by community planning stakeholders was the in-kind support provided to the Student Health Initiative by various partners. The most commonly cited support that organizations dedicated to this project was staff time. The amount of time provided was noted as being significant. One respondent indicated that the time was provided by both administrative staff and service providers within the partnering agencies.

> …this collaboration or initiative is in addition to a job one is already doing. So I find with new initiatives or collaborations or partnerships there is a tremendous amount of work and I think that often is not acknowledged-the amount of work that goes into it…it takes a lot of planning, a lot of negotiation-all those things that go with it and I think that has to be acknowledged. It is not accounted for anywhere in terms of dollars and cents and I think sometimes that has an impact on the initiatives as well.

The other in-kind supports mentioned by some respondents were related to the operation of the initiative. One respondent noted that finding space for staff was a challenge and that as a result it had to be provided on-site which was a cost to an organization. Another indicated that restrictions within the guidelines for this initiative did not recognize daily operating costs for organizations in providing services though it was noted that some of them were offset by administrative dollars and changes were made to the guidelines to address technological needs.

Key Learning

A number of areas of key learning were also identified by community planning stakeholders. A major learning highlighted was the need for clarity from the government regarding the target population for the initiative or mandate of the service. "And to be very specific-or more specific as to what you wanted done. So if they wanted you to serve (*children with)* mild-moderate *(disabilities)*.... As well, the importance of adequate and sustainable funding was raised. Issues such as the importance of acknowledging the cost of living or salary increases in funding as well as the constraints associated with time limited funding were discussed. The need for more time to engage in planning was a concern raised by a couple of respondents. One noted that three years was not an adequate time frame and that five to seven years was really what was required.

As well, two respondents identified the importance of the provincial role in the initial plan development at the local level. One highlighted the need for more support while the other highlighted the need for more clarity on the part of the province. The latter respondent noted that the original plan had been developed and approved by the province. Subsequent to this implementation began. However, in the midst of this they

were advised that their plan was not deemed to be a correct interpretation of the guidelines which resulted in staff who had been hired to implement the plan being laid off.

> ...I would have made sure that there was more discussion with the province, I think that they understood what we were doing...we did the plan, sent it in, they said "Yes, that's great" and we went ahead. And the implications of them not really approving our plan were huge ones. So I think that they didn't understand the impact it would have on us to have to change midstream.

Other areas of key learning named by one or two respondents were that collaboration takes time; involves politics; assists in service gap identification; promotes creativity/innovation in meeting needs; necessitates an understanding of other perspectives and negotiation; requires definitions of roles and responsibilities; and could be assisted by technology. Another respondent spoke at some length about community stakeholder involvement in the early stages of policy development (e.g., when the parameters of the initiative were being established) would have been extremely helpful. It was felt that this would have resulted in the creation of champions both at the governmental and community level who could have spoken around the province about the principles upon which the initiative was based.

There were also areas of key learning that were named by both policy and community planning stakeholders during the interviews. A major learning identified was the importance of leadership for collaboration. Specific types and levels of leadership noted included shared leadership at the community level, strategic leadership provided by the senior executive level within government to the provincial working group, and the existence of leadership at both the local and provincial level. The necessity for collaboration occurring not only at the local but also at the provincial level was also

raised. As well, the important role that relationships played in collaboration was highlighted. In addition, the need to focus on the group process aspects of this initiative in addition to outcomes was noted. For instance, one respondent indicated that monitoring of process on the part of government would have been beneficial while another noted so too would have been the provision of tools or guidance related to group processes.

> …you know there was nothing really ever that looked at, how is this partnership doing as a partnership, like how are they collaborating? It was always just about, are they getting their plan in and are they meeting all their requirements versus evaluating the actual strengths and workings of the partners.

Another area of key learning named by two respondents was the importance of helping partners understand that this initiative involved an equitable model which meant that no one partner was the lead. One key stakeholder indicated that this could have been done in a better way. Also, it was noted that the collaboration that took place within the Student Health Initiative led to partnering on other initiatives at both the local and provincial level.

CHAPTER 5

Discussion

The purpose of this study was to examine the intersectoral collaboration component of the Student Health Initiative, as conceptualized by the originators of the policy and implemented by community planning stakeholders through interviews and a review of pertinent documents. The specific areas of discussion that arise from this study of intersectoral collaboration include: (1) its meaning; (2) the rationale for and benefits of working in this way; (3) factors that facilitate this type of approach; and (4) its barriers and costs. Each of these areas will be summarized and compared to the literature. This will be followed by the strengths and limitations of the study.

The Meaning of Intersectoral Collaboration

Within the Student Health Initiative, various aspects of intersectoral collaboration were articulated in the planning guides provided to community planning stakeholders. These included the level and types of sectors to be involved in this initiative; the form that the collaboration was to take (e.g., a partnership); the type of activity to be implemented (e.g., enhancing provision of a range of integrated health services and related support services); and other expectations such as developing a shared vision, establishing open and clear communication and utilizing shared responsibility for decision-making and action. However, it was noted by some policy and community planning stakeholders that little attention was actually paid to the process of collaboration itself as evidenced by the lack of reporting requirements in this area (though the

Edmonton Student Health Initiative Partnership did indicate in its Joint Service Plan in 1999 that satisfaction with the partnership would be measured) and the lack of provision of tools to assist with group process.

Collaboration is a complex phenomenon. It has been described as involving different types and levels of participants, including all key stakeholders, taking on various forms, and being implemented through a range of activities (Harris et al., 1995). As well, the importance of open and frequent communication, developing a shared vision, and feeling ownership for the way the group operates and the outcomes of its work have been noted in the literature as factors related to successful collaboration (Mattessich et al., 2001).

Rationale and Benefits of Intersectoral Collaboration

Intersectoral collaboration was a mandatory component of the Student Health Initiative. The primary reasons for mandating this was to promote the notion of collective responsibility among various sectors for addressing the needs of children and because of the government's past experience of collaboration not occurring when funds were provided to one particular group. Other reasons cited for engaging in collaborative approaches included both preventing duplication and facilitating coordination of services. A number of tangible benefits of intersectoral collaboration at the community level were also identified. These included a greater understanding of partner organizations; increased collaboration regarding services, promotion of collaboration on other initiatives, and improvements in service. In conducting the member checks, one respondent noted that it would have been interesting to have asked families what they

thought of the Student Health Initiative as much of the impetus for this initiative came from the frustration of families: lack of co-ordination.

Preventing duplication (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1999; Harris et al., 1995), making more effective use of limited resources (Alter & Hage, 1993; Cohen, Baer & Satterwhite, 1998; Federal, Provincial, and Territorial Advisory Committee on Population Health, 1999; Harris et al., 1995) and co-ordination of services and programs (Alter & Hage, 1993) have all been noted in the literature as benefits of collaborative approaches.

Factors Promoting Intersectoral Collaboration

Several factors were identified as promoting intersectoral collaboration within the Student Health Initiative by community planning stakeholders and in a study of six of these partnerships across Alberta. These factors included having: a history of collaboration, consistent and appropriate membership at the table, and appropriate resources such as funding to implement the initiative. The other key factor named by community planning stakeholders was the commitment among partners in addressing the issue. Policy and community planning stakeholders also identified some important key learning related to this type of approach that are useful to highlight. These include recognition of the importance of leadership and relationships to collaboration; the necessity of collaboration occurring at both the local and provincial level; and the need to focus on process aspects of the initiative in addition to outcomes.

In addition, both policy and community planning stakeholders identified several supports that were put into place to promote intersectoral collaboration. These included

funding (including monies for administrative costs), planning guides, hiring a provincial coordinator and local coordinator, establishing a provincial working group, providing facilitators through Alberta Community Development to assist with planning processes and holding provincial forums for partnerships to share their experiences.

Mattessich et al., (2001) in their analysis of 22 studies identified a number of factors that impact on successful collaboration. One of these factors is a history of collaboration or cooperation in the community. This provides stakeholders with some sense of the roles and expectations related to collaboration and promotes trust in the process. Appropriate representation within the group is another important factor. When selecting members, consideration should be given to who has control over issues of relevance to the group. In addition, consistent representation from participating organizations is necessary to promote strong personal linkages within the group. Adequate funding, staffing, and materials as well as enough time to attain goals and foster collaboration and skilled leadership are also key to successful collaboration. In a study of stakeholder perspectives on factors that impact on successful collaboration, lack of commitment was identified as one of the major barriers (Johnson, et al., 2003).

Barriers and Costs of Intersectoral Collaboration

In this study, a number of barriers and costs associated with intersectoral collaboration were identified by respondents. The main barriers cited by both policy and community planning stakeholders were issues related to funding, time, and miscommunication. Of these, the first two barriers were also noted in documents that were reviewed. Another key barrier noted by policy stakeholders and community

planning stakeholders were differences that existed across the province which impacted on implementation and organizational differences respectively. Other barriers that were raised by both types of respondents included changes in membership within the partnership, and challenges with information sharing regarding clients related to different legislation.

Inadequate funding for collaborative work and lack of communication (Johnson et al., 2003) as well as insufficient time (Johnson et al., 2003; Swan & Morgan, 1993); not understanding other organization's cultures (Johnson et al., 2003); differences in professional cultures, training, and education; and issues with client confidentiality (Higgins, et al., 1994) have all been cited in the literature as barriers to collaboration.

The findings from this study have provided additional support for some of the rationale/benefits, factors, barriers and costs associated with intersectoral collaboration that have been identified in the literature. However, many gaps in the research still remain. These include the circumstances under which intersectoral collaboration should be implemented; the specific kinds and levels of resources needed to support this type of work; more detail on the benefits, costs, and barriers of this approach; the cost effectiveness of this strategy compared to others to address similar issues; the sustainability of this type of work given the different mandates and funding silos that exist between sectors; the range of outcomes that can be achieved through this approach; and whether evaluation results from these types of initiatives result in policy changes among funders/governmental bodies that mandate intersectoral collaboration.

Strengths and Limitations of the Study

Strengths

One of the primary strengths of this study was the opportunity to interview a range of key informants from various sectors at both the policy and community planning stakeholder levels about different aspects of intersectoral collaboration. Their insights added to the existing knowledge regarding the rationale for and benefits of working in this way, factors that facilitate this type of approach, and the barriers and costs associated with intersectoral collaboration.

Limitations

This study utilized a case study methodology which by its nature limits the generalizability of the findings as the experiences captured reflect those of individuals involved in a very specific initiative. However, it is interesting to note that the study findings do reflect a number of themes identified in the literature.

Chapter 6

Conclusions and Implications

Intersectoral collaboration is viewed as an important strategy to achieve health goals. Over the past several years there have been a number of government-funded initiatives that have required collaboration between sectors at the community level to address a wide range of issues. The Student Health Initiative is an example of government mandated intersectoral collaboration and provided a rich case study to examine the experiences of both policy and community planning stakeholders in supporting or participating in its implementation.

While there were a number of challenges, overall the collaboration aspect of the Student Health Initiative was viewed as a positive experience by community planning stakeholders. The recognition of the tremendous need for services that existed within the community for families and children, and the opportunity afforded through this initiative to some degree address these needs were strong motivators. Beyond providing more services for children and the development of new services, there were additional benefits of collaboration noted at the community level. These included improved understanding of partner organizations, increased collaboration regarding services, and promotion of collaboration related to other initiatives. Several factors were also identified as promoting intersectoral collaboration. These included a history of collaboration, consistent and appropriate membership, and adequate resources.

In addition to the benefits, there were also barriers and costs experienced by community planning stakeholders in engaging in intersectoral collaboration. The key

barriers were related to various aspects of time, funding, and communication regarding the initiative's purpose/scope. The costs identified were linked to the daily operation of the initiative. Several supports were also put into place to promote intersectoral collaboration; however, the pace of development, purpose, and resources related to the Student Health Initiative posed implementation challenges. These barriers and costs appeared to be beyond the scope of local partnerships to address and seemed to require intervention at a policy level to be resolved. The findings from this study provide some insights into intersectoral collaboration which may be of value to policy, research, and practice.

Policy Implications

1. Both the conditions for successful collaboration and its barriers have been articulated in the literature. There is a need to ensure broad dissemination of this information to policy makers.
2. The conditions for successful collaboration and its barriers should be taken into consideration when developing policy on collaborative initiatives.
3. Collaboration requires significant resources on the part of individual organizations in terms of time and staffing. It is important that these "in-kind" contributions be considered in the funding provided for collaborative initiatives.
4. Having a dedicated staffing position to support the partnership in the form of a coordinator was important and should be considered in the funding of collaborative initiatives.

5. A three year funding period for this type of complex collaborative initiative is too short and longer term funding should be considered.
6. For planning and service delivery purposes it is important that funding levels be sustained from year to year thus it is important that any funding formula account for this.
7. Forming partnerships requires time and this needs to be built into the implementation timelines of collaborative initiatives.
8. Forming partnerships involves group process and it is important to provide process support (e.g., staff with expertise in group process, tools to assist with collaboration) to the development of partnerships
9. Consumer involvement is important in collaborative initiatives and mechanisms need to be put into place to ensure that this occurs.
10. When implementing new collaborative initiatives, encourage appropriate groups with a history of collaboration within the community to apply for funding.

Research Implications

1. Within collaborative initiatives, ensure that the functioning of partnerships is an outcome that is measured.
2. Utilize standardized and validated tools to assess the functioning of partnerships.
3. Publish evaluations of collaborative initiatives in peer reviewed journals.
4. Examine the cost effectiveness of collaborative initiatives.
5. Ensure that outcome evaluations are a part of government funded collaborative initiatives.

6. Examine the differences between voluntary and mandated collaboration.
7. Examine the impact of projects such as the student health initiative upon participating user groups (e.g. families).

Practice Implications

1. Both the conditions for successful collaboration and its barriers have been articulated in the literature. There is a need to ensure broad dissemination of this information to community planning stakeholders.
2. The conditions for successful collaboration and its barriers should be taken into consideration when implementing collaborative initiatives and interdisciplinary education initiatives in post secondary institutions.
3. Organizations participating in collaborative initiatives should provide the appropriate level of representation and consistent membership at planning tables.

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Appendices

Appendix A

Interview Guide-Policy Level

Prior to beginning the interview, the researcher will thank the participant for agreeing to be interviewed; undertake the informed consent process and have the participant sign the consent form; and will answer any questions that he/she may have.

1. Could you please describe your role in shaping and/or overseeing the intersectoral collaboration component of the Student Health Initiative?
2. How is intersectoral collaboration defined within the Student Health Initiative?
3. Why is intersectoral collaboration mandated in the Student Health Initiative?
4. What supports to intersectoral collaboration were considered in the development of the policy?
5. What types of supports were put in place to facilitate intersectoral collaboration at the community planning stakeholder level?
6. How were the barriers to intersectoral collaboration addressed in the development of the policy?
7. What are the key learnings about intersectoral collaboration at the community planning stakeholder level?
8. Can you identify key documents that indicate how intersectoral collaboration was conceptualized at the policy level?
9. Can you identify key documents that indicate what types of supports were put in place by policy makers to promote intersectoral collaboration among community planning stakeholders?
10. Are there other key individuals at the policy level that you think I should interview about the Student Health Initiative?
11. Do you have any other thoughts that you would like to share with me?

Appendix B

Interview Guide-Community Planning Stakeholder

Prior to beginning the interview, the researcher will thank the participant for agreeing to be interviewed; undertake the informed consent process and have the participant sign the consent form; and will answer any questions that he/she may have.

1. Could you please describe your role in implementing the Student Health Initiative?

2. What does the term intersectoral collaboration mean to you? How is this similar or different to how it was defined within the Student Health Initiative?

3. Can you describe what it was like to implement the intersectoral collaboration component of the Student Health Initiative? What factors promoted intersectoral collaboration? What were the barriers to intersectoral collaboration?

4. What were the benefits of the intersectoral component of the Student Health Initiative?

5. What were the costs associated with the intersectoral collaboration of the Student Health Initiative?

6. What types of support/resources were put into place to facilitate intersectoral collaboration among community partners?

7. What have you learned about intersectoral collaboration from your experience implementing the Student Health Initiative?

8. Are there key ESHIP documents that indicate how the intersectoral collaboration component of the Student Health Initiative was interpreted and implemented by community planning stakeholders?

9. Are there other key present or past members of ESHIP that you feel I should interview?

10. Do you have any other thoughts that you would like to share with me?

Appendix C

Information Letter

I am a graduate student in the Master of Science in Health Promotion Program at the University of Alberta and would like to invite you to participate in a research study entitled "Intersectoral Collaboration for Health: The Student Health Initiative". I am conducting this research as the basis for my master's thesis. The purpose of the study is to examine the intersectoral collaboration component of the Alberta government's Student Health Initiative, as conceptualized by the originators of the policy and implemented by community planning stakeholders. Your participation in this study will contribute to the development of knowledge in this area and will assist policy makers and community planning stakeholders to establish a firm foundation for engaging in intersectoral collaboration.

As part of my research I will be conducting a document review and semi-structured interviews with members of the Student Health Initiative Provincial Working Group and members of the Edmonton Student Health Initiative Partnership (ESHIP) Steering Committee. These interviews will last approximately one hour in length and will be taped. As well, I will be taking notes throughout the interview. Once I have compiled and analyzed all of the information that you have provided I will contact you at a later date to review and confirm its accuracy.

Your participation is voluntary and you are free to decline answering any questions. As well, you can withdraw from the interview at any time.

All information will be held confidential (or private), except when professional codes of ethics or legislation (or the law) requires reporting.

The information you provide will be kept for at least five years after the study is done. The information will be kept in a secure area (i.e. locked filing cabinet). Your name or other identifying information will not be attached to the information you gave. Your name will also never be used in any presentations or publications of the study results.

The information gathered for this study may be used for other research in the future if the researcher receives approval from an ethics review committee

This study will be used primarily for my Master's thesis; however, the results may be presented at conferences and published in journals and reports. The anonymity and confidentiality of the participants will be maintained at all times. If you are interested in participating in the study or have any questions, please do not hesitate to contact either myself or my thesis supervisor: